Delaware Medicaid Disproportionate Share (DSH) Program
For Hospital Fiscal Year Ending in 2010
Instructions for Completing the DMMA DSH Application (DMMA Form DSH 1)
April 2012

Federal regulations allow state Medicaid programs to make payments to hospitals that serve a disproportionate share of Medicaid and uninsured patients. The federal regulations specify certain qualifying criteria and in addition, permit the establishment of state specific criteria. A limited amount of Federal Medicaid funds are available to each state for this purpose, and can only be utilized to the extent that state matching funds are available. In order to qualify, a hospital must submit a timely application to DMMA, provide the required information, and be determined by DMMA to meet the requirements of the DSH program.

In 2012, DMMA revised the Medicaid DSH qualifying criteria. The revisions have been approved by CMS (the Federal Medicaid agency). Therefore, DMMA is announcing the process and schedule for applying for Medicaid DSH payments based on data for the hospital's fiscal year ending in calendar year 2010.

Note – applying for Medicaid DSH payments is optional. If a hospital does not apply, that does not affect the hospital's participation in any other aspect of the Medicaid program.

DSH Application Due Date – A Delaware hospital wishing to apply for Medicaid DSH payments for the hospital fiscal year ending in calendar year 2010 must submit an application which must be received by DMMA by 4:30 Eastern time on May 18, 2012.

DSH Payments – DMMA hopes to issue DSH payments to any hospital that qualifies based on 2010 fiscal year data on or before June 30, 2012 or as soon thereafter as possible.

Audit Requirements – State Medicaid agencies that issue DSH payments are required to provide the Federal government with an independent audit verifying that the information provided by each hospital that submits an application is accurate. The State may issue the payments based on the information submitted prior to the audit. A hospital is required to repay any DSH payments received that are subsequently determined to be overpayments.

If a hospital qualifies for a DSH payment based on the DSH 1 forms submitted with 2010 fiscal year data, DMMA expects to audit those hospital reports on or before June 30, 2013.

A. General Instructions - DMMA Form DSH 1:

1. In completing Form DSH 1, note that there are 3 tabs in the Excel document. Complete all three tabs.

2. The data requested on this report is for the hospital's fiscal year that ended in calendar year 2010.

3. For questions about these instructions for Form DSH 1, contact Frank O'Connor @ 302 255 9615 or via e-mail: frank.oconnor@state.de.us

4. The completed Form DSH 1 (including all three (3) tabs in the Excel workbook) must be returned via US mail, other delivery service or hand delivered to:

   Division of Medicaid and Medical Assistance
   P O Box 906
   DHSS Holloway Campus – Lewis Building
   1901 N DuPont Hwy
   New Castle, De 19720

   Form DSH 1 may also be submitted electronically via e-mail as an Excel or PDF document to:

   frank.oconnor@state.de.us

5. If the hospital offers inpatient hospital services at more than one geographical location and submits a consolidated Medicare cost report, the hospital must submit a single DMMA Form DSH 1 report. Otherwise, submit a separate DMMA Form DSH 1 for each inpatient hospital location.

6. Complete each line of the report only with the information requested for that line. For example, if inpatient information is requested, only provide inpatient information not combined inpatient and outpatient data. If charges are requested, only provide charges, not revenue or cost data. If the specific information is not available then leave that line blank.

7. If a hospital is not able to provide the requested information for each line on the report, it may still be to the advantage of the hospital to complete as much information as possible and submit a timely report. Leave blank any information that the hospital does not have and provide the information that is available.

8. Do not enter the number 0 (zero) if data is unavailable for a particular line. Leave the line blank of enter “unknown” or “not available”.

B. Line by Line Instructions – DMMA Form DSH 1:

Line #	Instructions
	Hospital Fiscal Year -- enter the fiscal year that this report pertains to.
	For Profit or Not for Profit -- delete the one that does not apply.
	IMD or Acute Care or Other – delete the ones that do not apply.
1.	If the hospital offers **inpatient services** at more than one geographic location, answer “Yes” or else answer “No” (two or more building on the same campus is one geographic location)
2.	If the answer to #1 above is “No”, answer “NA” to this question. If the answer to #1 above is “Yes”, and if the hospital files a consolidated Medicare cost report, answer “Yes” to this questions. Otherwise answer “No” to this question (and file a separate report for each inpatient facility).
3.	If the hospital’s inpatient population is predominately individuals under age 18 year of age, answer “NA”. Otherwise, answer “yes” or “no” if the hospital offers obstetric services to the general public.
4.	If the answer to #3 is “No” or “NA”, answer “NA” to this question. Otherwise, answer “yes” or “no” if the hospital has at least two (2) obstetricians (or two physicians in the case of a rural hospital) with staff privileges who have agreed to provide obstetric services to individuals who are entitled to Medicaid. Note: if the answer on line #3 is “yes” and the answer on line #4 is “no”, the hospital cannot qualify for DSH payments according to Federal regulations.
5.	If you answer “No” or “NA” to questions #2 or #3 or #4, leave this question blank. Otherwise, give the address of the inpatient facility(s) that provide full obstetrical care to the general public including Medicaid recipients.
6.	In order to qualify for DSH, the hospital must be continuously enrolled as a Medicaid provider for the 24 month period ending in the month that the DSH payments are expected to be made. This includes enrollment with the Medicaid fee-for-service program as well as with all Medicaid managed care organizations.
7.	Enter the number of total annual **inpatient** bed days for the hospital’s fiscal year. This includes all Medicaid and non-Medicaid patients.
8.	Enter the number of total annual **inpatient** bed days for person’s who were eligible for Medicaid during the hospital’s fiscal year. This includes Medicaid individuals covered by the DMMA fee-for-service program as well as persons covered by the DMMA managed care program (DPCI or United).
9.	Enter the total annual dollar amount of all **inpatient** hospital charges during the hospital’s fiscal year.
10.	Enter the total annual dollar amount of all **inpatient** hospital **charity care** charges during the hospital’s fiscal year.
11.	Enter the total annual dollar amount of the **cost** of **inpatient and outpatient** services for **Medicaid** patients including fee-for-service and those enrolled in managed care. Note: cost should be based on a ratio of cost to charges that

	covers all applicable hospital costs and charges relating to inpatient and outpatient care and does not distinguish among payer types such as Medicare, Medicaid, other insurers or private pay. This number should be copied from the DSH Supplement Form tab in the Excel workbook.
12.	Enter the total annual dollar amount of the **cost** of **inpatient and outpatient** services for **uninsured** patients. Note: cost should be based on a ratio of cost to charges that covers all applicable hospital costs and charges relating to inpatient and outpatient care and does not distinguish among payer types such as Medicare, Medicaid, other insurers or private pay. This number should be copied from the DSH Supplement Form tab in the Excel workbook.
13.	Enter the total annual dollar amount of all **revenue (i.e., payments received**) for all **inpatient and outpatient** services during the hospital's fiscal year.
14.	Enter the total annual dollar amount of all **revenue (i.e., payments received)** for all **Medicaid** fee-for-service **inpatient and outpatient** services during the hospital's fiscal year.
15.	Enter the total annual dollar amount of all **revenue (i.e., payments received)** for all **Medicaid** patients enrolled in managed care (DPCI or United) **inpatient and outpatient** services during the hospital's fiscal year.
16.	Add the Medicaid revenue amounts on lines 14 and 15. This number should be copied from the DSH Supplement Form tab in the Excel workbook.
17.	Enter the Total Annual Federal Section 1011 Payments received by the hospital for eligible aliens (should also be included in the amount on line 13). This number should be copied from the DSH Supplement Form tab in the Excel workbook.
18.	Enter the total annual **inpatient and outpatient revenue/payments** received by the hospital during the year being reported by or on behalf of **uninsured** persons (should also be included in the amount on line 13). This number should be copied from the DSH Supplement Form tab in the Excel workbook.
19.	The amount on line 11 (**cost** of **inpatient and outpatient services for Medicaid)** minus the amount on line 16 (total **revenue** for **Medicaid inpatient and outpatient services**). This may be a negative number. This number should be copied from the DSH Supplement Form tab in the Excel workbook.
20.	From the amount on line 12 (**cost** of **inpatient and outpatient services for the uninsured)**, subtract the amounts on lines 17 and 18. This number should be copied from the DSH Supplement Form tab in the Excel workbook.
21.	Add the amounts from line 19 and line 20. This number should be copied from the DSH Supplement Form tab in the Excel workbook.
22.	Signature – the Form DSH 1 should be signed by the person completing the form. If the form is submitted electronically, the signature page can be scanned and submitted as a PDF file.

Definitions:

Term	Definitions for Form DMMA DSH 1
Cost	Cost should be based on a ratio of cost to charges that covers all applicable hospital costs and charges relating to inpatient and outpatient care for the year being reported and does not distinguish among payer types such as Medicare, Medicaid, other insurers or private pay. Costs and charges cannot include physician services provided to the uninsured. Perform the calculation on the DSH Supplement Form.
Inmates of public institutions for which Medicaid funds are not available	Means outpatient services provided to prisoners (inpatient services provided to prisoners are eligible for Medicaid funding) and persons in IMD's whose cost of care is not Medicaid reimbursable.
Inpatient hospital Charity Care Charges	The total amount of hospital charges for inpatient services attributable to charity care. These charges do not include bad debt charges, contractual allowances, or discounts given to legally liable third party payers.
Revenue	Means payment received from any source.
Uninsured	Means a person who has no source of third party coverage.